Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife Philippines and China Banking Corporation

Arthritis Questionnaire

Last Name: ______________________________ First Name: ______________________________
Please Print

Date of Birth: ______________________________ Policy/Application Number: ____________________

1. Please state the precise diagnosis, or nature of the condition that you are suffering from e.g. Rheumatoid Arthritis, Osteoarthritis, Ankylosing Spondylitis, Reiter's Syndrome, Psoriatic Arthritis, etc.

2. When did you first experience symptoms? / /

3. Please describe your symptoms fully:

4. a) Are these symptoms ongoing? Yes No

   b) If yes, are they worsening in severity? Yes No

   c) When did you last experience symptoms? / /

   d) Which joints are or have been affected e.g. left wrist, both wrists, right ankle, etc?

   e) Are your daily activities affected or restricted in any way? Yes No
   If yes, please provide details:

   f) Do you use a walking stick or other mobility aid? Yes No
   If yes, please provide details:

5. Do you currently take medication for this condition? Yes No
If yes, please provide details including names, dosages and frequency where applicable:

Name of medication	Dose	Frequency

6. Have you taken medications in the past for this condition? Yes No
If yes, please provide details including names, dosages, frequency and dates where applicable:

Name of medication	Dose	Frequency	Date last taken

7. Has any other treatment, test or investigation been carried out in connection with this condition e.g. blood tests, x-ray, arthroscopy, surgery etc.? Yes No

If yes, please provide details including dates, procedures, locations and results:

Name of treatment, test or investigation	Location	Date	Results

8. Have you ever been admitted to hospital or had out-patient follow-up for this condition? Yes No

If yes, please provide details including dates, procedures, locations and results:

9. Has any future treatment or investigation been discussed or contemplated, such as change in medication, surgery or other therapy? Yes No

If yes, please provide details:

10. Please provide the name and address of the doctors and/or specialists you see in relation to this condition:

Name of doctor, hospital or clinic	Address	Date of last consult

11. Have you ever taken time off work with this condition? Yes No

If yes, please provide dates and durations:

12. Have your working duties ever been affected or restricted in any way? Yes No

If yes, please provide details including dates and durations:

13. Please provide any additional information that you feel is important:

Declaration

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

Name	Signature	Date / /